FOR BHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041533

Facility Name: Heritage Manor-Pana

Address: 1000 East Sixth Street Road (Number) Pana (City) 62557 (Zip Code)

County: Montgomery

Telephone Number: (217) 324-2153 **Fax #** ( )

HFS ID Number: 370909086020

Date of Initial License for Current Owners: 1996

Type of Ownership:

	VOLUNTARY,NON-PROFIT	xx	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		xx	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Craig Ater **Telephone Number:** (309)823-7135

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Craig L. Ater

(Title) Senior V.P. & CFO

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Heritage Manor-Pana # 0041533 Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	151	Skilled (SNF)	151	55,115	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	151	TOTALS	151	55,115	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	30,856	10,614	5,632	47,102	8
9	SNF/PED			0		9
10	ICF					10
11	ICF/DD					11
12	SC	0	0	0		12
13	DD 16 OR LESS					13
14	TOTALS	30,856	10,614	5,632	47,102	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.46%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [xx]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [xx]

I. On what date did you start providing long term care at this location?
Date started 1996

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [xx]

K. Was the facility certified for Medicare during the reporting year?
YES [xx] NO [ ] If YES, enter number of beds certified _____ and days of care provided 5,632

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [xx] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Heritage Manor-Pana # 0041533 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	214,488	22,167		236,655		236,655	6,665	243,320			1
2	Food Purchase		243,820		243,820		243,820		243,820			2
3	Housekeeping	89,139	19,798		108,937		108,937	7	108,944			3
4	Laundry	82,549	30,735		113,284		113,284		113,284			4
5	Heat and Other Utilities			124,581	124,581		124,581	2,104	126,685			5
6	Maintenance	89,405	54,471	22,519	166,395		166,395	17,628	184,023			6
7	Other (specify):*											7
8	TOTAL General Services	475,581	370,991	147,100	993,672		993,672	26,404	1,020,076			8
	B. Health Care and Programs											
9	Medical Director			4,200	4,200		4,200		4,200			9
10	Nursing and Medical Records	1,828,810	75,090	15,511	1,919,411		1,919,411		1,919,411			10
10a	Therapy		289,030	507,557	796,587	(689,632)	106,955	369,680	476,635			10a
11	Activities	76,614	1,032		77,646		77,646		77,646			11
12	Social Services	53,458		3,253	56,711		56,711		56,711			12
13	CNA Training		156		156		156	2,369	2,525			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,958,882	365,308	530,521	2,854,711	(689,632)	2,165,079	372,049	2,537,128			16
	C. General Administration											
17	Administrative	83,353			83,353		83,353	102,186	185,539			17
18	Directors Fees							7,586	7,586			18
19	Professional Services			385,654	385,654		385,654	(364,577)	21,077			19
20	Dues, Fees, Subscriptions & Promotions			116,163	116,163	(82,673)	33,490	(3,140)	30,350			20
21	Clerical & General Office Expenses	124,044	15,302	18,650	157,996		157,996	210,921	368,917			21
22	Employee Benefits & Payroll Taxes			542,476	542,476		542,476	54,898	597,374			22
23	Inservice Training & Education			5,389	5,389		5,389	(3,390)	1,999			23
24	Travel and Seminar			10,461	10,461		10,461	(8,462)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			99,535	99,535		99,535	2,692	102,227			26
27	Other (specify):*			12,304	12,304		12,304	(12,000)	304			27
28	TOTAL General Administration	207,397	15,302	1,190,632	1,413,331	(82,673)	1,330,658	(13,286)	1,317,372			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,641,860	751,601	1,868,253	5,261,714	(772,305)	4,489,409	385,167	4,874,576			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Heritage Manor-Pana #0041533 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			119,599	119,599		119,599	17,888	137,487			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			225,678	225,678		225,678	30,949	256,627			32
33	Real Estate Taxes			67,680	67,680		67,680		67,680			33
34	Rent-Facility & Grounds							9,239	9,239			34
35	Rent-Equipment & Vehicles			19,754	19,754		19,754	1,243	20,997			35
36	Other (specify):*											36
37	**TOTAL Ownership**			432,711	432,711		432,711	59,319	492,030			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					689,632	689,632		689,632			39
40	Barber and Beauty Shops		1,124	22,376	23,500		23,500		23,500			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					82,673	82,673		82,673			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		1,124	22,376	23,500	772,305	795,805		795,805			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,641,860	752,725	2,323,340	5,717,925		5,717,925	444,486	6,162,411			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Heritage Manor-Pana # 0041533 Report Period Beginning: 01/01/05 Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(1,075)	35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(193)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(725)	20		17
18	Fines and Penalties				18
19	Entertainment	(22,522)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,992)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,000)	27		24
25	Fund Raising, Advertising and Promotional	(8,829)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(5,167)	23		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (55,503)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	499,989		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 499,989		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 444,486		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Heritage Manor-Pana

ID# 0041533

Report Period Beginning: 01/01/05

Ending: 12/31/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5		(1,075)	35	5
6		0	34	6
7				7
8				8
9		0	30	9
10			32	10
11				11
12				12
13		0	2	13
14			32	14
15		0	33	15
16			24	16
17		(725)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(4,992)	19	22
23				23
24		(12,000)	27	24
25		(8,829)	20	25
26				26
27				27
28				28
29		(5,167)	23	29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(32,788)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Heritage Manor-Pana **#** 0041533 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	6,665	0	0	0	0	0	0	0	0	6,665	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	7	0	0	0	0	0	0	0	0	7	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	2,104	0	0	0	0	0	0	0	0	2,104	5
6	Maintenance	0	0	17,628	0	0	0	0	0	0	0	0	17,628	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	26,404	0	0	0	0	0	0	0	0	26,404	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	369,680	0	0	0	0	0	0	0	0	0	369,680	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	2,369	0	0	0	0	0	0	0	0	2,369	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	369,680	2,369	0	0	0	0	0	0	0	0	372,049	16
	C. General Administration													
17	Administrative	0	0	102,186	0	0	0	0	0	0	0	0	102,186	17
18	Directors Fees	0	0	7,586	0	0	0	0	0	0	0	0	7,586	18
19	Professional Services	(4,992)	(380,662)	21,077	0	0	0	0	0	0	0	0	(364,577)	19
20	Fees, Subscriptions & Promotions	(9,554)	0	6,414	0	0	0	0	0	0	0	0	(3,140)	20
21	Clerical & General Office Expenses	0	0	210,921	0	0	0	0	0	0	0	0	210,921	21
22	Employee Benefits & Payroll Taxes	0	0	54,898	0	0	0	0	0	0	0	0	54,898	22
23	Inservice Training & Education	(5,167)	0	1,777	0	0	0	0	0	0	0	0	(3,390)	23
24	Travel and Seminar	(22,522)	0	14,060	0	0	0	0	0	0	0	0	(8,462)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,692	0	0	0	0	0	0	0	0	2,692	26
27	Other (specify):*	(12,000)	0	0	0	0	0	0	0	0	0	0	(12,000)	27
28	**TOTAL General Administration**	(54,235)	(380,662)	421,611	0	0	0	0	0	0	0	0	(13,286)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(54,235)	(10,982)	450,384	0	0	0	0	0	0	0	0	385,167	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Heritage Manor-Pana **#** 0041533 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	17,888	0	0	0	0	0	0	0	17,888	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(193)	0	0	31,142	0	0	0	0	0	0	0	30,949	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	9,239	0	0	0	0	0	0	0	9,239	34
35	Rent-Equipment & Vehicles	(1,075)	0	0	2,318	0	0	0	0	0	0	0	1,243	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,268)	0	0	60,587	0	0	0	0	0	0	0	59,319	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(55,503)	(10,982)	450,384	60,587	0	0	0	0	0	0	0	444,486	45

Facility Name & ID Number Heritage Manor-Pana # 0041533 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [xx] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V	10a	Adjustment for Related Organization						2
3	V								3
4	V	19	Adjustment for Related Organization	380,662	Heritage Enterprises, Inc.	100.00%		(380,662)	4
5	V								5
6	V	10a	Adjustment for Related Organization	286,005	GreenTree Pharmacy	100.00%	655,685	369,680	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 666,667			$ 655,685	$ * (10,982)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heritage Manor-Pana # 0041533 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Heritage Enterprises, Inc.	100.00%	$ 6,665	$ 6,665	15
16	V	2	Food Purchase				0		16
17	V	3	Housekeeping				7	7	17
18	V	4	Laundry				0		18
19	V	5	Heat & Other Utilities				2,104	2,104	19
20	V	6	Maintenance				17,628	17,628	20
21	V	7	Other				0		21
22	V	9	Medical Director				0		22
23	V	10	Nursing & Medical Records				0		23
24	V	11	Activities				0		24
25	V	12	Social Service				0		25
26	V	13	Nurse Aide Training				2,369	2,369	26
27	V	14	Program Transportation				0		27
28	V	15	Other				0		28
29	V	17	Administrative				102,186	102,186	29
30	V	18	Directors Fees				7,586	7,586	30
31	V	19	Professional Services				21,077	21,077	31
32	V	20	Fees, Subscription, Promotions				6,414	6,414	32
33	V	21	Clerical & General Office Expenses				210,921	210,921	33
34	V	22	Employee Benefits & Payroll Taxes				54,898	54,898	34
35	V	23	Inservice Training & Education				1,777	1,777	35
36	V	24	Travel and Seminar				14,060	14,060	36
37	V	25	Other Admin. Staff Transportation				0		37
38	V	26	Insurance-Prop.Liab.Malpract				2,692	2,692	38
39	Total			$			$ 450,384	$ * 450,384	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heritage Manor-Pana # 0041533 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	27	Other	$	Heritage Enterprises, Inc.	100.00%	$	$ 0	15
16	V	30	Depreciation					17,888	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					31,142	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					9,239	20
21	V	35	Rent-Equipment & Vehicles					2,318	21
22	V	36	Other					0	22
23	V	38	Medically Nec Transportation					0	23
24	V	39	Ancillary Service Centers					0	24
25	V	40	Barber and Beauty Shops					0	25
26	V	41	Coffee and Gift Shops					0	26
27	V	42	Other					0	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ * 60,587	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heritage Manor-Pana # 0041533 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Susie Jefferson	Director	Management	15.86				Salary/BOD	$ 23,059	Ln 17 & 18	1
2	Estate of Tom Jefferson			16.21				Salary/BOD	0	Ln 17 & 18	2
3	Craig Hart	Chairman	Management	31.95				Salary/BOD	25,858	Ln 17 & 18	3
4	Cheryl Lowney	Executive Vice Presi	Management	0.49		40	100.00	Salary/BOD	15,397	Ln 17 & 18	4
5	Steve Wannemacher	President	Management	0.42		40	100.00	Salary/BOD	20,065	Ln 17 & 18	5
6	Connie Hoselton	Sr Vice President	Management	0.27		40	100.00	Salary	9,900	Ln 17 & 18	6
7	Craig Ater	Sr Vice President	Management	0.34		40	100.00	Salary	11,096	Ln 17 & 18	7
8	Ben Hart	Vice President	Management	3.20		40	100.00	Salary	4,397	Ln 17 & 18	8
9											9
10											10
11											11
12											12
13								TOTAL	$ 109,772		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number Heritage Manor-Pana # 0041533 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [xx] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Heritage Enterprises
Street Address: 115 W. Jefferson
City / State / Zip Code: Bloomington,Il
Phone Number: ( )
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Beds	2,612	25	$ 115,289	$ 115,276	151	$ 6,665	1
2	2	Food Purchase	Beds	2,612	25	7	0	151	0	2
3	3	Housekeeping	Beds	2,612	25	124	0	151	7	3
4	4	Laundry	Beds	2,612	25	0	0	151	0	4
5	5	Heat & Other Utilities	Beds	2,612	25	36,387	0	151	2,104	5
6	6	Maintenance	Beds	2,612	25	304,933	79,110	151	17,628	6
7	7	Other	Beds	2,612	25	0	0	151	0	7
8	9	Medical Director	Beds	2,612	25	0	0	151	0	8
9	10	Nursing & Medical Records	Beds	2,612	25	0	0	151	0	9
10	11	Activities	Beds	2,612	25	0	0	151	0	10
11	12	Social Service	Beds	2,612	25	0	0	151	0	11
12	13	Nurse Aide Training	Beds	2,612	25	40,976	40,976	151	2,369	12
13	14	Program Transportation	Beds	2,612	25	0	0	151	0	13
14	15	Other	Beds	2,612	25	0	0	151	0	14
15	17	Administrative	Beds	2,612	25	1,767,611	1,767,611	151	102,186	15
16	18	Directors Fees	Beds	2,612	25	131,223	0	151	7,586	16
17	19	Professional Services	Beds	2,612	25	364,592	0	151	21,077	17
18	20	Fees, Subscription, Promotions	Beds	2,612	25	110,958	0	151	6,414	18
19	21	Clerical & General Office Expens	Beds	2,612	25	3,648,522	3,309,912	151	210,921	19
20	22	Employee Benefits & Payroll Taxe	Beds	2,612	25	949,625	0	151	54,898	20
21	23	Inservice Training & Education	Beds	2,612	25	30,747	0	151	1,777	21
22	24	Travel and Seminar	Beds	2,612	25	243,204	0	151	14,060	22
23	25	Other Admin. Staff Transportatio	Beds	2,612	25	0	0	151	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,612	25	46,560	0	151	2,692	24
25	TOTALS					$ 7,790,758	$ 5,312,885		$ 450,384	25

Facility Name & ID Number Heritage Manor-Pana # 0041533 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,612	25	$	$	151	$	1
2	30	Depreciation	Beds	2,612	25	309,426		151	17,888	2
3	31	Amortization of Pre-Op & Org	Beds	2,612	25			151		3
4	32	Interest	Beds	2,612	25	538,695		151	31,142	4
5	33	Real Estate Taxes	Beds	2,612	25			151		5
6	34	Rent-Facility & Grounds	Beds	2,612	25	159,809		151	9,239	6
7	35	Rent-Equipment & Vehicles	Beds	2,612	25	40,093		151	2,318	7
8	36	Other	Beds	2,612	25			151		8
9	38	Medically Nec Transportation	Beds	2,612	25			151		9
10	39	Ancillary Service Centers	Beds	2,612	25			151		10
11	40	Barber and Beauty Shops	Beds	2,612	25			151		11
12	41	Coffee and Gift Shops	Beds	2,612	25			151		12
13	42	Other	Beds	2,612	25			151		13
14								151		14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,048,023	$		$ 60,587	25

Facility Name & ID Number Heritage Manor-Pana # 0041533 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	LsSalle National Bank		xx	Mortgage	4640 plus Int	01/15/99	$	$ 2,898,088	01/15/06	variable	$ 190,470	1
2	LsSalle National Bank		xx	Mortgage							9,811	2
3												3
4												4
5												5
	Working Capital											
6	Central Office Allocation		xx	Working Capital							25,397	6
7	Central Office Allocation		xx	Working Capital								7
8												8
9	TOTAL Facility Related						$	$ 2,898,088			$ 225,678	9
	B. Non-Facility Related*											
10	Interest Income										(193)	10
11												11
12											31,142	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 30,949	14
15	TOTALS (line 9+line14)						$	$ 2,898,088			$ 256,627	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* **Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

** **If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Heritage Manor-Pana **#** 0041533 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.	***Important*** **,** please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 58,463	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 61,533	2
3. Under or (over) accrual (line 2 minus line 1).		$ 3,070	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 64,610	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 67,680	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	57,273	8
	2001	54,205	9
	2002	49,636	10
	2003	55,832	11
	2004	57,719	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Manor-Pana COUNTY Montgomery

FACILITY IDPH LICENSE NUMBER 0041533

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-25-22-223-014	Heritage Manor-Pana	$ 60,883.00	$ 60,883.00
2.	11-25-22-223-013		$ 650.00	$ 650.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 61,533.00	$ 61,533.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Heritage Manor-Pana # 0041533 Report Period Beginning: 01/01/05 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,284 B. General Construction Type: Exterior brick/wood Frame wood Number of Stories 1

C. Does the Operating Entity? [xx] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [xx] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

none

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [xx] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$ 51,055	1
2					2
3	TOTALS			$ 51,055	3

Facility Name & ID Number Heritage Manor-Pana # 0041533 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	87				$ 3,943,054	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	Smoke Detectors			1997	1,113						10
11											11
12	Seal BlackTop/Parking Lot			1996	2,680						12
13	Heritage Manor Sign			1996	2,192						13
14	Laundry Room Central A/C			1996	3,019						14
15											15
16	Generator Repair			1998	1,559						16
17	Roof			1998	26,420						17
18											18
19	roof			1999	113,936						19
20											20
21	Heat / Cool Unit			2000	1,170						21
22	Roof Repair Walkway			2000	1,715						22
23											23
24											24
25	Tile Floor			2001	1,646						25
26	Heat/Cool Unit			2001	1,180						26
27											27
28	Day Room Carpet			2002	1,225						28
29	Hot Water Heater			2002	2,224						29
30	Sewar repair			2002	1,965						30
31											31
32											32
33											33
34	C/O Allocation							17,888	17,888		34
35	Book Depreciation					107,550		107,550		1,011,658	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Heritage Manor-Pana # 0041533 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38	Sealcoat Parking Lot	2003	3,338						38
39	A/C unit	2003	1,153						39
40	Key Service Unit	2003	1,063						40
41	Carpeting	2003	5,655						41
42	Ansul System	2003	1,803						42
43									43
44	Booster Heater	2004	1,151						44
45	Energy Mgt System	2004	12,890						45
46	Exterior Doors	2004	1,247						46
47	Heat/Cool Units	2004	7,372						47
48	Drive way repairs	2004	1,765						48
49	Carpeting	2004	13,652						49
50	Sewer Replacement	2004	2,847						50
51									51
52	Heat/Cool Units	2005	13,286						52
53	Unerfloor Ductwork	2005	1,100						53
54	Sidewalks	2005	9,208						54
55	Roof	2005	4,161						55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,186,789	$ 107,550		$ 125,438	$ 17,888	$ 1,011,658	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Heritage Manor-Pana # 0041533 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,186,789	$ 107,550		$ 125,438	$ 17,888	$ 1,011,658	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,186,789	$ 107,550		$ 125,438	$ 17,888	$ 1,011,658	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Heritage Manor-Pana # 0041533 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 393,435	$ 12,049	$ 12,049	$		$ 370,395	71
72	Current Year Purchases	47,883						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 441,318	$ 12,049	$ 12,049	$		$ 370,395	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,679,162	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 119,599	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 137,487	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 17,888	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,382,053	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Heritage Manor-Pana # 0041533 Report Period Beginning: 01/01/05 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 20,997 Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Heritage Manor-Pana # 0041533 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- COMMUNITY COLLEGE ☐
- HOURS PER CNA ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		156		156
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 156	$	$ 156
10	SUM OF line 9, col. 1 and 2 (e)	$ 156			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Heritage Manor-Pana # 0041533 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$ 172,717	$		$ 172,717	1
2	Licensed Speech and Language Development Therapist		hrs			108,681			108,681	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			192,212	3,025		195,237	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				655,685		655,685	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					33,947			33,947	13
14	TOTAL			$		$ 507,557	$ 658,710		$ 1,166,267	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Heritage Manor-Pana **#** 0041533 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/05 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 11,353	$	1
2	Cash-Patient Deposits	19,059		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	621,286		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	11,556		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	4,075,897		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,739,151	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	51,055		13
14	Buildings, at Historical Cost	4,186,789		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	441,318		16
17	Accumulated Depreciation (book methods)	(1,382,053)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	31,069		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,328,178	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,067,329	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 84,338	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	19,059		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	322,280		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,985		31
32	Accrued Real Estate Taxes(Sch.IX-B)	64,610		32
33	Accrued Interest Payable	18,067		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 511,339	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,898,088		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,898,088	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,409,427	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,657,902	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,067,329	$	48

***(See instructions.)**

Facility Name & ID Number Heritage Manor-Pana **#** 0041533 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,061,546	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,061,546	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	596,356	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 596,356	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 4,657,902	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number Heritage Manor-Pana # 0041533 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,246,907	1
2	Discounts and Allowances for all Levels	(1,824,798)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,422,109	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,327,114	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,327,114	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	4,020	12
13	Barber and Beauty Care	22,664	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	537,964	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	217	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 564,865	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	193	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 193	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,314,281	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	993,672	31
32	Health Care	2,854,711	32
33	General Administration	1,413,331	33
	B. Capital Expense		
34	Ownership	432,711	34
	C. Ancillary Expense		
35	Special Cost Centers	23,500	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,717,925	40
41	**Income before Income Taxes (line 30 minus line 40)****	596,356	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 596,356	43

*** This must agree with page 4, line 45, column 4.**

**** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

***** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Heritage Manor-Pana # 0041533 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,848	2,099	$ 57,171	$ 27.24	1
2	Assistant Director of Nursing	3,049	3,497	65,863	18.83	2
3	Registered Nurses	5,727	5,911	142,484	24.10	3
4	Licensed Practical Nurses	20,140	21,889	346,337	15.82	4
5	CNAs & Orderlies	119,819	129,138	1,172,659	9.08	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,882	3,175	44,296	13.95	8
9	Activity Director					9
10	Activity Assistants	6,800	7,780	76,614	9.85	10
11	Social Service Workers	3,211	3,817	53,458	14.01	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,431	25,396	214,488	8.45	15
16	Dishwashers					16
17	Maintenance Workers	6,253	6,723	89,405	13.30	17
18	Housekeepers	12,303	13,123	89,139	6.79	18
19	Laundry	8,182	8,856	82,549	9.32	19
20	Administrator	1,900	2,080	83,353	40.07	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,613	9,723	124,044	12.76	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	224,158	243,207	$ 2,641,860 *	$ 10.86	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		$ 0		35
36	Medical Director		4,200		36
37	Medical Records Consultant		8,451		37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,990		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		3,253		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 19,894		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	0	$ 0		50
51	Licensed Practical Nurses	0	0		51
52	Certified Nurse Assistants/Aides	0	0		52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Heritage Manor-Pana # 0041533 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Nancy Prior	admin		$ 83,353
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 83,353

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$ 380,662
		0
		0
		0
		4,992
		0
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 385,654

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 68,378
Unemployment Compensation Insurance	52,793
FICA Taxes	202,102
Employee Health Insurance	200,915
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Hepatitis Vaccine	1,859
Employee Benefits -	16,429
Employee Benefits - central office	54,898
TOTAL (agree to Schedule V, line 22, col.8)	$ 597,374

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 0
Advertising: Employee Recruitment	13,199
Health Care Worker Background Check	
(Indicate # of checks performed)	310
Central Office Allocation	6,414
Promotional Advertising	2,025
Public Relations	6,804
Dues and Subscriptions	10,054
License and Fees	1,098
Less: Public Relations Expense	(6,804)
Non-allowable advertising	(725)
Yellow page advertising	(2,025)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 30,350

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	3,789
	0
Seminar Expense	6,672
	(22,522)
	14,060
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,999

**See instructions.

Facility Name & ID Number Heritage Manor-Pana # 0041533 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number **Heritage Manor-Pana** **#** **0041533** **Report Period Beginning:** **01/01/05** **Ending:** **12/31/05**

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **Illinois Healthcare Association**

(3) Did the nursing home make political contributions or payments to a political action organization? **yes** If YES, have these costs been properly adjusted out of the cost report? **yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **7 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,000** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **xx** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **xx** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **82,673**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **no** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **yes** Indicate the amount. $ **2,142**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **yes**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **yes**
Firm Name: **Sulaski & Webb** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Not available**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **yes**
Attach invoices and a summary of services for all architect and appraisal fees.

BASIC CHARGE-PRIVATE & VA	-5,691,079	
PRIVATE ASSESSMENT TAX INCOME		
BASIC CHARGE-IPA	0	
BASIC CHARGE-MEDICARE	0	
DAY CARE/HOME CARE		
LIGHT NURSING CARE	-98,677	
MEDIUM NURSING CARE		
HEAVY NURSING CARE		
SPECIALTY NURSING CARE		
NURSING SUPPLIES-PRIVATE	-308,262	
NURSING SUPPLIES-IPA		
NURSING SUPPLIES MED PT A		
NURSING SUPPLIES MED PT B		
DRUGS	-537,964	
DRUGS-OTHER		
PT-PRIVATE	-1,327,114	
PT-IPA		
PT-MEDICARE PART A		
PT-MEDICARE PART B		
PT-MEDICARE ASSESSMENT INC		
LABORATORY INCOME		
SPEECH/OT-PRIVATE		
SPEECH/OT-IPA		
SPEECH/OT-MED PART A		
SPEECH/OT MED PART B		
IPA DISCOUNTS	1,824,798	
MEDICAID PART B DISCOUNT		
MEDICARE DISCOUNTS		
ASSESSMENT TAX EXPENSE		
RENT INCOME	0	
BEAUTY SHOP	-22,664	
ACTIVITY FUND INCOME	-8	
ACTIVITY FUND EXPENSE	-4,652	
MANAGEMENT FEES		
EQUIPMENT RENTAL	-148,889	
RESIDENT TRANSPORTATION	-317	
MISC INCOME	0	
GENERAL & ADMINIST WAGES	116,705	124,044
ADMINISTRATOR WAGES	83,353	83,353
VACATION & SICK - G&A	7,339	
EMPLOYEE BENEFITS	14,429	542,476
EMPLOYEE HEPETITIS VACCINE	1,059	
EMPLOYEE SCHOLORSHIP WAC	0	
EMPLOYEE SCHOLORSHIP COST	0	
DIRECTORS FEES		
OFFICE EXPENSES	15,302	15,302
TELEPHONE	18,650	18,650
TRAINING & EMPLOYEE DEVL	5,389	5,389
GENERAL TRAVEL	3,709	10,461
MEAL EXPENSE FOR TRAVEL	0	
EDUCATION & SEMINAR	6,672	
HELP WANTED ADVERTISING	13,199	116,163
PROMOTIONAL ADVERTISING	2,025	
PUBLIC RELATIONS	6,884	
LICENSES & FEES	83,771	
DUES & SUBSCRIPTIONS	10,054	
CONTRIBUTIONS	0	
PROFESSIONAL FEES	4,992	385,454
AUDIT & LEGAL FEES	4,200	4,200
UTILIZATION REVIEW	0	
OTHER PHYSICIAN FEES	0	
MEDICAL RECORDS CONSULT	8,451	
PHARMACIST FEES	3,990	
SOC SERV/ACT CONSULT	3,253	3,253
TV RENTAL	1,886	
INCOME TAXES		12,304
BACKGROUND CHECKS	310	
PAYROLL TAXES	247,912	
PAYROLL TAXES ADMINIST	4,583	
UNEMPLOYMENT	200,515	
LIABILITY INSURANCE	99,135	99,135
INSURANCE-OWNERS		
WORKMENS COMP INSURANCE	68,378	
CENTRAL OFFICE FEES	380,662	
BAD DEBTS	11,000	
LOST ITEMS-RESIDENTS	304	
MISCELLANEOUS	0	
REAL ESTATE TAXES	67,680	67,680
LEASED EQUIPMENT	17,868	18,754
MAINTENANCE SALARIES	84,023	89,485
MAINTENANCE SICK & VAC	5,382	
ELECTRIC	58,678	124,581
NATURAL GAS	44,976	
HEATING & DIESEL OIL		
WATER & SEWER	20,927	
TRASH COLLECTION	4,185	22,519
PROPERTY PLANT REPLACEMN	7,183	54,471
GENERAL REPAIR & MAINT	47,288	
MAINTENANCE CONTRACTS	18,334	
DIETARY WAGES	203,922	214,488
DIETARY SICK & VAC	10,566	
SALES TAX		
FOOD PURCHASES	245,962	243,820
SUPPLIES-DISHWASHING	4,472	22,417
DIETARY REPLACEMENT	1,854	
DIETARY SUPPLIES-PAPER	4,944	
MEAL CREDIT	-3,142	
LAUNDRY WAGES	77,382	82,549
LAUNDRY SICK & VAC	5,167	
LAUNDRY REPLACEMENT	20,758	30,735
LAUNDRY REIMBURSEMENT		
LAUNDRY SUPPLIES	9,977	
HOUSEKEEPING WAGES	85,605	86,139
HOUSEKEEPING SICK & VAC	3,534	
HOUSEKEEPING SUPPLIES	6,956	19,788
HOUSEKEEPING SUPPLIES-PPR	12,842	
RN WAGES-MEDICARE		1,828,810
RN WAGES-NON MEDICARE	128,690	
RN BONUS	1,000	
ADON	65,463	
RN SICK & VACATION	14,394	
LPN WAGES-MEDICARE	0	
LPN WAGES-NON MEDICARE	326,412	
LPN WAGES OTHER		
LPN SICK & VACATION	19,925	
AIDE WAGES-MEDICARE		
AIDE WAGES-NON MEDICARE	1,073,839	
WARD CLERKS		
AIDE VACATION & SICK	98,020	
CONTRACT NURSES-RN	0	
CONTRACT NURSES-LPN	0	
CONTRACT NURSES-AIDES	0	
NURSE AIDE TRAINING WAGES	0	0
NURSE AID TRAINING EXP	156	156
NURSE AIDE TRAINING REIMB	0	
REHAB WAGES	41,006	
REHAB SICK & VAC	3,290	
NURSING DEPT EDUCATION		
NURSING SUPPLIES	52,617	75,090
NURSING SUPPLIES	18,988	
REPLACEMENT-NURSING	3,475	
NURSING-OTHER	3,070	15,511
DRUG PURCHASES	162,000	289,030
DRUG PURCHASES-OTHER	123,679	
LABORATORY SERVICES	33,947	507,327
HOME HEALTH SALARY		
HOME HEALTH SICK & VAC		
HOME HEALTH EXPENSES		
ACTIVITIES WAGES	70,797	76,614
ACTIVITIES SICK & VAC	5,817	
ACTIVITIES SUPPLIES	1,032	1,032
ACTIVITIES FEES	0	0
PT WAGES		
PT SICK & VACATION		
PT FEES	192,213	
PT SUPPLIES	3,025	
SOCIAL SERVICE WAGES	47,536	53,458
SOCIAL SERVICE SICK & VAC	5,922	
SOCIAL SERVICE EXPENSES	0	0
OT FEE	172,717	
SOCIAL THERAPIST FEE	0	0
SPEECH THERAPY FEE	108,681	
BEAUTICIAN WAGES		0
BEAUTICIAN SICK & VAC		
BEAUTICIAN FEES	22,376	22,376
BEAUTY SHOP SUPPLIES	1,124	1,124
VOLUNTEER COORDINATOR		
VOL COORD SICK & VAC		
VOL COORD SUPPLIES	0	
RENT		0
INTEREST EXPENSE	215,867	225,670
DEPRECIATION	119,599	119,599
LOAN FEE AMORTIZATION	9,811	
INTEREST INCOME	-193	
MISC NON-OPERATING INCOME	0	
INCOME TAXES	0	
	5,717,732	5,717,925
		193
	-106,356	
	(NET INCOME)	
	0	

						2,612	151	3,471,750	71,391,262	
	Name	Title	Function	Total Pay	ısted by Mgmt F	otal # Beds	acility # Be	on-Nursing Hor	Nursing Home	This Facility
###	Susie Jefferson	Director	Manageme	418,245	418,245			19,396	398,849	23,059
###	Tom Jefferson	Secretary	Manageme	0	0			0	0	0
###	Craig Hart	Chairman	Manageme	469,049	469,049			21,752	447,297	25,858
###	Cheryl Lowney	Executive Vice Presic	Manageme	279,290	279,290			12,952	266,338	15,397
###	Steve Wannemache	President	Manageme	363,969	363,969			16,879	347,090	20,065
###	Connie Hoselton	Sr Vice President	Manageme	179,584	179,584			8,328	171,256	9,900
###	Craig Ater	Sr Vice President	Manageme	201,279	201,279			9,334	191,945	11,096
	Ben Hart			79,758	79,758			3,699	76,059	4,397
13				1,991,174	1,991,174				1,898,834	109,772